



Original communication

Training in clinical forensic medicine in the UK – Perceptions of current regulatory standards

Margaret M. Stark LLM MSc Med Ed FFFLM FACBS FHEA DGM DMJ(Clin) DAB DME Founding Academic Dean ^{a,*}, Guy A. Norfolk MBChB LLM FRCP FFFLM MRCGP DMJ (Clin) Founding President ^{a,b}

^a Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London, UK

^b Stockwood Medical Centre, Hollway Road, Bristol BS14 8PT, UK

ARTICLE INFO

Article history:

Received 23 April 2011

Accepted 10 May 2011

Available online 14 June 2011

Keywords:

Clinical forensic medicine

Initial training

Workplace-based assessments

Regulatory standards

ABSTRACT

As clinical forensic medicine (CFM) is not currently recognised as a speciality in the UK there are no nationally agreed mandatory standards for training forensic physicians in either general forensic (GFM) or sexual offence medicine (SOM).

The General Medical Council (GMC), the medical regulator in the UK, has issued clear standards for training in all specialities recommending that “trainees must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload and time to learn”.

In order to evaluate the current situation in the field of clinical forensic medicine, doctors who have recently (within the last two years) started working in the field “trainees” ($n = 38$), and trainers ($n = 61$) with responsibility for clinical and educational supervision of new trainees, were surveyed by questionnaire to gather their perceptions of how the relevant GMC standards are being met in initial on-the-job training. Telephone interviews were performed with eleven doctors working as clinical or medical directors to determine their views.

It is clear that currently the quality of training in CFM is sub-standard and inconsistent and that the published standards, as to the minimum requirement for training that must be met by post-graduate medical and training providers at all levels, are not being met.

The Faculty of Forensic and Legal Medicine (FFLM) needs to set explicit minimum standards which will comply with the regulator and work to pilot credentialing for forensic physicians. A number of recommendations are made for urgent FFLM development.

© 2011 Elsevier Ltd and Faculty of Forensic and Legal Medicine. All rights reserved.

1. Introduction

Although clinical forensic medicine (CFM) is not currently recognised as a speciality or sub-speciality in the UK it is abundantly clear that there is a need to produce forensic physicians trained to serve the stakeholders of CFM, mainly of course the public, as patients and as part of protecting the wider community; the police; lawyers; forensic scientists; social workers; etc.

Appropriate training of staff and continuing professional development is a core element of clinical governance. A recent review has suggested that robust clinical governance procedures underpinning the provision of CFM services have rarely been achieved; and that the competencies and training required are not fully defined.¹

Post-graduate training in the UK has until recently been regulated by the post-graduate Medical Education and Training Board (PMETB), an independent statutory body covering all the specialities and sub-specialities. On April 1st 2010, PMETB merged with the General Medical Council (GMC) which is now responsible for all stages of medical education and training. The standards and requirements for all organisations whether NHS, other service providers, or the independent sector, are outlined in three documents.^{2–4}

Good Medical Practice outlines the duties of a doctor.⁵ For the individual doctor providing care, the GMC is clear that the doctor must recognise and work within the limits of his/her competence. For trainers it is essential to develop the skills, attitudes and practices of a competent teacher and to ensure that any staff for whom the trainer has a responsibility are appropriately supervised.

The issues currently facing Clinical Forensic Medicine in the UK are huge with fragmentation of service provision, minimal

* Corresponding author. Tel.: +44 1275 833103; fax: +44 1372 748901.

E-mail address: margaretmarystark@gmail.com (M.M. Stark).

regulation and concerns over quality. In early 2010 the Faculty of Forensic and Legal Medicine (FFLM) published Interim Quality Standards for training covering the fields of general forensic (GFM) and sexual offence medicine (SOM) for consultation.⁶ Credentialing, defined as a “process which provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined area of practice at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice”,⁷ has been proposed⁸ as a way forward to ensure competence.

The relevant GMC domain in the generic standards for training,² namely domain 6, has the following key mandatory requirements for doctors:

- The need for an induction to understand their duties, reporting arrangements and departmental policies, and to meet key staff;
- Trainees must have an educational supervisor;
- Trainees should have a log book/learning portfolio and meet with an educational supervisor regularly;
- Trainees must have a means of feeding back to a local faculty member, in confidence, any concerns and their views about the training and educational environment.

This domain also includes the standards for trainers who must provide a level of supervision appropriate to the competence and experience of the trainee with the following requirements:

- Use of approved in work assessment tools;
- Ability to regularly review the trainee's progress through the training programme and be able to give formative feedback;
- Advise on career development;
- Be able to deal with a “failing trainee”;
- Have had training and have resources to perform the role;
- Have access to support from other trainers and the faculty/organisation.

The GMC also publishes standards for curricula and assessment systems³ which include having specific trainer/supervisor input and appropriate assessment.

Previously, Stark⁹ surveyed doctors working as educational supervisors within the London area where a need for further training for this role was identified. Furthermore earlier fieldwork¹⁰ looking at the quality of the initial training in London found an overwhelming need for a more formal structure to the training of newly appointed forensic physicians.

This research aims to assess the quality of training from a national perspective, which will be very important for the FFLM in developing an improved training programme that would be acceptable to the regulators.

2. Methodology

A survey of trainers and trainees (defined as doctors who had started working in the field within the past two years) was performed using a web-based Questionnaire (Quask). The wide variation in service provision means that there is no central, accurate and comprehensive database of these practitioners. Therefore the Faculty database of forensic practitioners at the time of the survey (58 Fellows, 265 Members, and 189 Affiliates)¹¹ was used as a pragmatic approach to accessing relevant subjects for inclusion. It is recognised that there may be many other doctors working in the field who have not joined the FFLM. An email message was sent to the FFLM database of forensic practitioners by the FFLM administrator with a link to the online survey; this ensured anonymity of the data.

This method accessed a greater number of subjects easily, quickly, and cheaply and provided a simple method of a follow-up by way of a reminder email message. An explanatory covering email from the President of the FFLM was sent with the questionnaire stressing the importance of the research for Faculty development, which hopefully increased the response rate.

The development of the questionnaires was based on an adaptation from the post-graduate Hospital Educational Environment Measure (PHEEM)¹² which had been the basis of previous research in London performed with a limited number of trainees using a semi-structured interview pro forma¹⁰ and a questionnaire survey of trainers in London.⁹

The questionnaires (available from MS) were piloted so that ambiguous questions and other difficulties in question design, were removed. Many questions required simple factual answers but for some questions a Likert rating scale was used to enable a more differentiated answer rather than the simple yes/no approach.

2.1. Interview sample

Six medical directors (MD), whose companies provide forensic healthcare services to constabularies, and five clinical directors of Sexual Assault Referral Centres (SARC) were selected from both rural and urban areas for interview. Following the initial analysis of the questionnaire responses from trainees and trainers outlined above and referring to the GMC criteria,² a semi-structured pro forma was used for the telephone interviews. Open-ended questions were used to gather the directors' perceptions of how the relevant GMC standards are being met in initial on-the-job training in clinical forensic medicine in their area of practice.

The advantage of interviewing¹³ the directors was to obtain an account of the training they are able to provide considering the current constraints, if any, in which they practice. The use of a telephone interview was pragmatic as the directors were based all over the country making other options such as face to face interviews or focus group discussion more time-consuming and expensive to arrange.

Informed consent was obtained for audio-taping of the interviews. The audio-tapes were transcribed and returned to the interviewees for accuracy and to ask for any further comments since the interview – respondent validation.¹⁴

The transcribed interviews were then analysed for themes to attempt to find repeated patterns of meaning.¹⁵ No major new themes were emerging in the data collection in the last interview. A peer reviewed the interview transcripts independently to look for themes, investigator triangulation.¹⁶

The three sets of data – trainee survey, trainer survey, and interviews of the medical directors are looking at the situation in different settings – data triangulation,¹⁷ hopefully giving differing perspectives in attempting to answer the research question.

2.2. Ethics

The full research proposal was submitted to the Research Ethics Committee Co-ordinator at St George's, University of London in January 2010 and the project was considered a survey (audit) and therefore not considered to be research under the NHS research governance arrangements.¹⁸

The research proposal was sent to and discussed at the Academic Committee of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London and the project received unanimous support from the Faculty.

3. Results

There were 38 questionnaires returned in relation to the trainee group and 61 in relation to the trainer group. Of the trainee group 37% ($n = 14$) had worked longer than the defined 'trainee' two years but because of the data collection method it was not possible to exclude them from the overall analysis of the questionnaire results. It should be remembered that the total number of potential responders is unknown and no follow-up of non-responders could be done apart from the reminder email. The data collected from the questionnaires was analysed using descriptive statistics.

3.1. Background of respondents

There were 38 respondents in the trainee survey: 21% ($n = 8$) working in the field of sexual offence medicine (SOM); 34% ($n = 13$) in the field of general forensic medicine (GFM); and 45% ($n = 17$) in both SOM/GFM. 63% ($n = 24$) of respondents had been working for two years or less (Table 1) which meant that 37% had been working longer for two years.

For the trainer survey there were 61 respondents: 25% ($n = 15$) working in the field of SOM; 23% ($n = 14$) working in the GFM; and 53% ($n = 32$) in both SOM/GFM. 79% ($n = 48$) had been working for over 6 years (Table 2).

Most of the trainee sample (46%; $n = 17$) had been or were currently practising general practice (GP) (Table 3); other areas (35%) mentioned included general medicine, sexual health, orthopaedics, general surgery, geriatrics, radiology and occupational medicine.

With regard to the trainers, the overwhelming background of the doctors was general practice (64% $n = 37$) (Table 4) but other specialities were mentioned, including forensic pathology, sexual health, paediatrics, public health, surgery, urology, substance misuse, pre-hospital care, respiratory medicine.

Only 33% ($n = 12$) of trainees and 60% ($n = 37$) of trainers held a Certificate of Completion of Training (CCT) or equivalent e.g. Certificate of Completion of Specialist Training, Certificate of Eligibility of Specialist Training, Joint Committee on post-graduate Training for General Practice in e.g. general practice, genitourinary medicine (GUM), pathology, paediatrics and obstetrics & gynaecology. 83% ($n = 50$) of the trainers were Foundation Members/

Table 1

Length of time (months) working in the field of clinical forensic medicine—'trainee'.

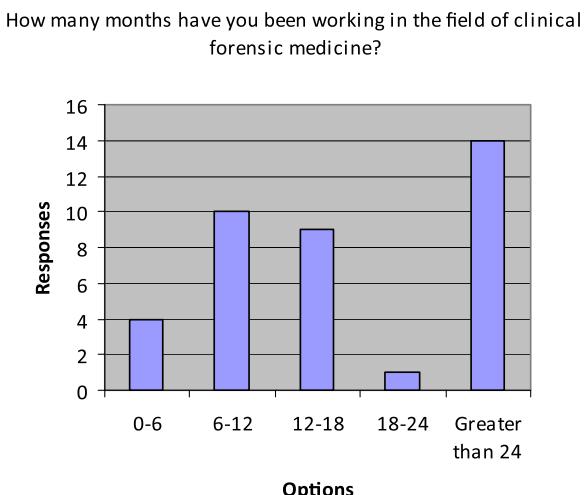
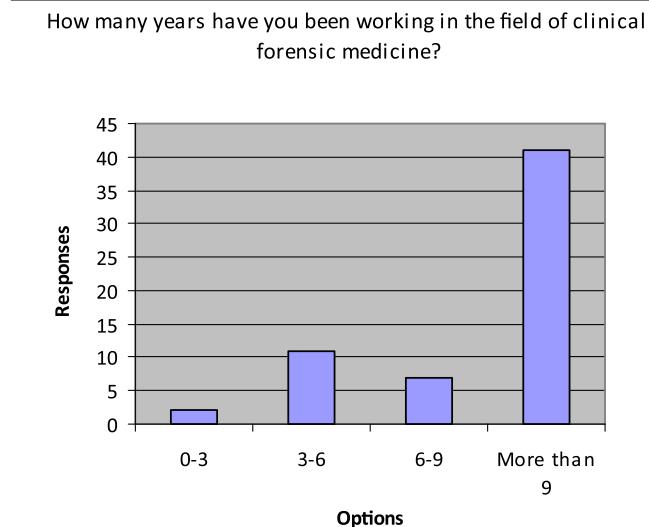


Table 2

Length of time (years) working in the field of clinical forensic medicine—'trainer'.



Fellows of the FFLM by virtue of a variety of post-graduate qualifications and had been training doctors on average eight years.

With regard to specific training on how to be an educational/clinical supervisor 51% ($n = 31$) had no previous training. The 49% ($n = 30$) who did have specific training gave examples such as: qualified GP trainer; the "train the trainers" courses; MA, Diploma and/or PG Cert in Medical Education; Consultant in the NHS; certificate in workplace training; RCPCH College Tutor; university lecturer; appraiser training course; informal training from GP tutors/course organisers.

3.2. Induction and initial training

71% ($n = 27$) of trainee respondents had attended an introductory training course; of which 37% ($n = 10$) attended the National Police Improvement Agency/Faculty of Forensic and Legal Medicine initial training course for GFM; 22.2% ($n = 6$) attended the St. Mary's Manchester training course and 11% ($n = 3$) the London Haven training course and 30% ($n = 8$) other courses. Other courses included introductory courses within private companies who provide forensic medical services to police authorities. 63% stated

Table 3

Other areas of medical practice—'trainees'.

In which other areas of medicine do you/practise (tick all that apply)?

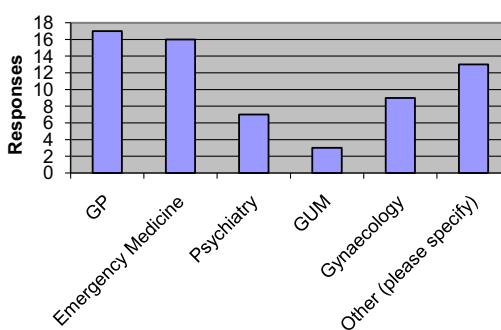
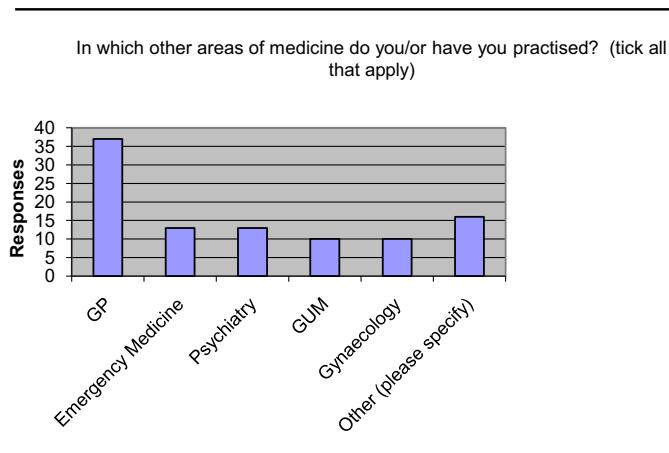


Table 4
Other areas of medical practice –‘trainers’.



that the course attendance was between 0 and 7 months prior to starting work. Most 84% ($n = 32$) had shadowed an experienced FP before starting work on their own and the period of shadowing is given below (Table 5).

Three quarters (76%) of the trainee respondents had an induction to: understand duties; reporting arrangements; group/constabulary/company policies; and to meet key staff (Table 6). 74% had guidelines or protocols in place to assist – either in-house protocols or FFLM guidance.

3.3. Supervision

53% ($n = 20$) of trainees were given a named clinical/educational supervisor (experienced FP) to oversee the initial on-the job training but only 68% ($n = 26$) felt that they had good clinical supervision at all times (someone to phone when help was required). 72% ($n = 26$) did not have regular meetings with the supervisor to discuss progress and assess particular training needs.

Only 36% ($n = 22$) of trainer respondents had protected time for meetings with the trainee. Examples were given: such as 1–3 h per week; 1 h per month; informal meetings as and when; when on duty so not really protected.

Although 57% ($n = 21$) of trainees kept a log book of cases seen (Table 7), only 33% ($n = 9$) discussed the log book with the supervisor; 55% ($n = 21$) kept a learning portfolio (Table 8) but only 24% ($n = 6$) discussed this with the supervisor. Only 50% ($n = 19$) of the

Table 5
Period of shadowing.

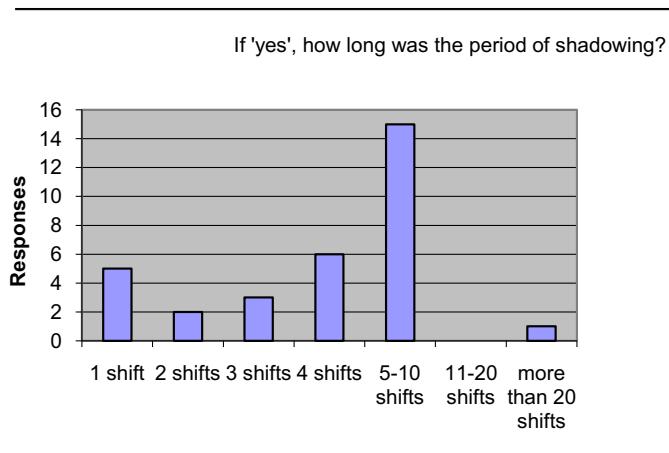
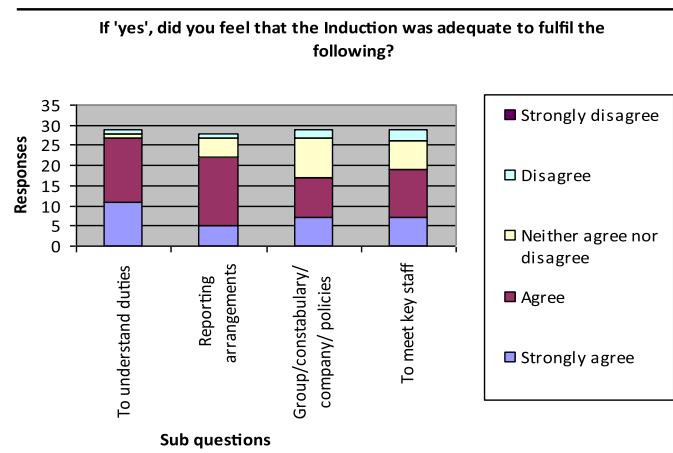


Table 6
Quality of induction training.



trainees had regular meetings/liaison with doctors working in the area but of those meetings 90% ($n = 19$) had an educational component (peer group meetings/support).

The trainees reported that only 19% ($n = 7$) of supervisors used the Faculty practical induction training guide (Table 9) and of those 21% ($n = 4$) received the ‘certificate of achievement of a standard of minimal acceptable competence in CFM’ (Table 10) with 13% ($n = 5$) having an independent evaluation of performance before being signed off as having the initial core competencies (Table 11). Two-thirds of doctors (66% $n = 22$) in training had no access to an independent senior doctor to feedback any concerns regarding the training.

39% ($n = 23$) of the trainers reported using the FFLM practical induction training programme (Table 12); 53% ($n = 31$) using a log book for training (Table 13); 45% ($n = 27$) using a learning portfolio (Table 14) but only 41% ($n = 25$) using any form of summative assessment (Table 15).

A few examples were given of the types of assessment processes used such as: part of the Forensic and Medical Examination for Rape & Sexual Assault Course (FMERSA course) is summative; post-graduate diploma courses; in-house continuous assessment forms; Workplace-based assessments (WPBAs) such as Objectively Structured Assessment of Technical Skills (OSATS- piloted in Obstetrics and Gynaecology), Direct Observation of Procedural Skills (DOPS),

Table 7
Use of log book—trainee.

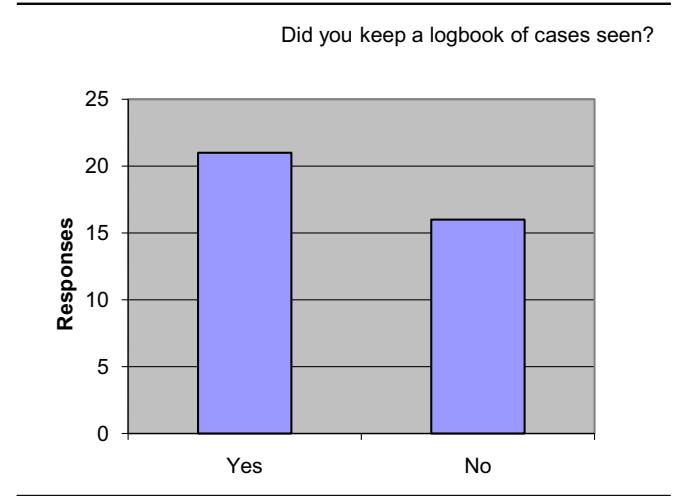
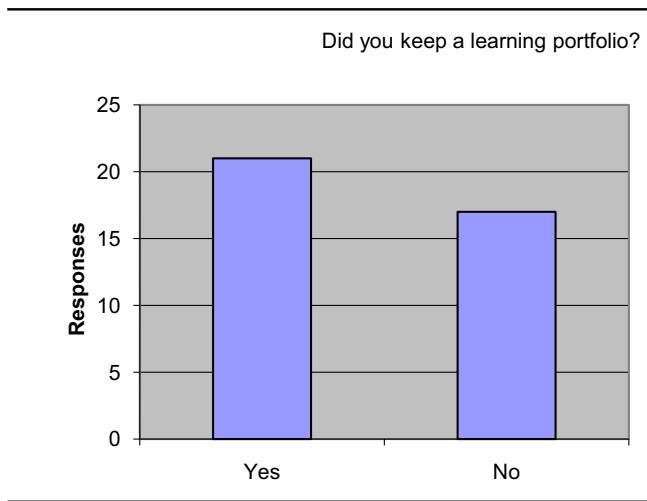


Table 8
Learning portfolio—trainee.



Mini Clinical Evaluation Exercise(Mini CEX), Case Based Discussions, reflective practice as set out in the RCOG post grad training; assessment of monthly written assignments; review of log books of cases seen, peer review assessments; accreditation process which includes supervision of cases, review of records and formal statements; encouraged to take on the existing post-graduate qualifications, etc.

Only 26% ($n = 16$) issued the 'certificate of achievement of a standard of minimal acceptable competence in CFM' at the end of the training period (Table 16) with only 33% ($n = 20$) having an assessment from an independent senior forensic physician (Table 17).

60% ($n = 22$) of trainee respondents stated that they plan to take the Membership of FFLM when eligible.

3.4. Resources

Only 27% ($n = 16$) thought they had sufficient resources to perform the training role (Table 18).

Table 9
Use of FFLM training guide—trainee.

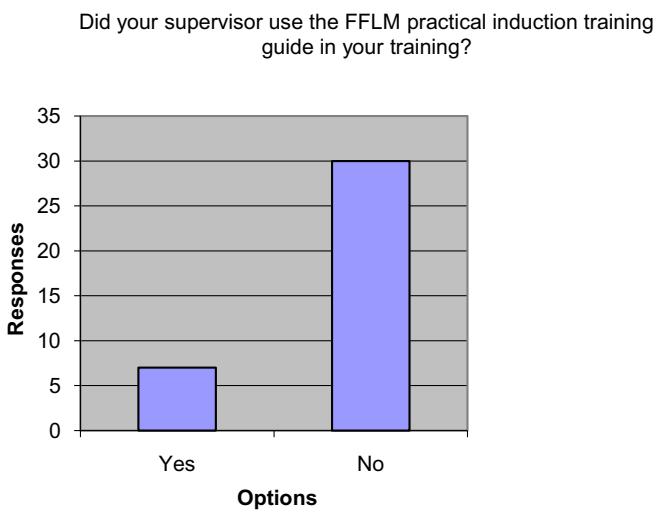
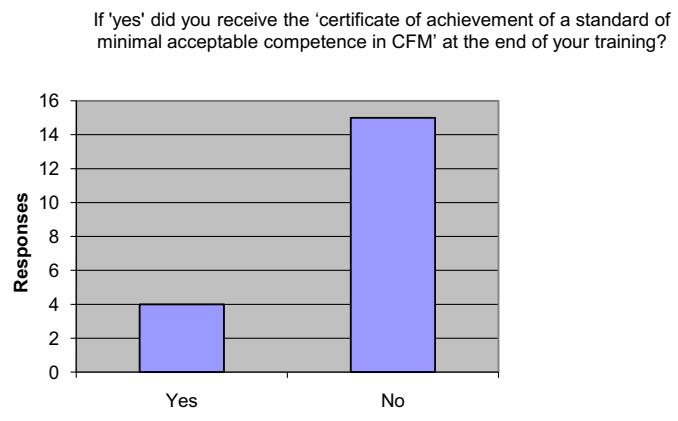


Table 10
Certificate of competence given—trainee.



Comments made when trainers were asked what further resources were needed included: protected paid time for trainers to be trained in the required skill set for training; protected paid time for training trainees; more formal recognition of the skill set required by trainers; recent problems with the changes to service provision with outsourced providers reluctant to fund external courses and the largest police service in London (MPS) no longer having the ability to train new recruits were mentioned; the need for a more formal system of training with comparisons drawn with the current training system in general practice.

3.5. Failing trainee

71% ($n = 43$) felt able to deal with a 'failing trainee' (Table 19) but a number of suggested improvements were given, including:

- Having an external source of advice and support within the faculty
- Formal recognised procedures, assistance from other trainers for second opinion and remedial support
- A course to be trainer is essential
- By standardising training requirements and having formal assessments
- Better network of local trainers

Table 11
Independent evaluation—trainee.

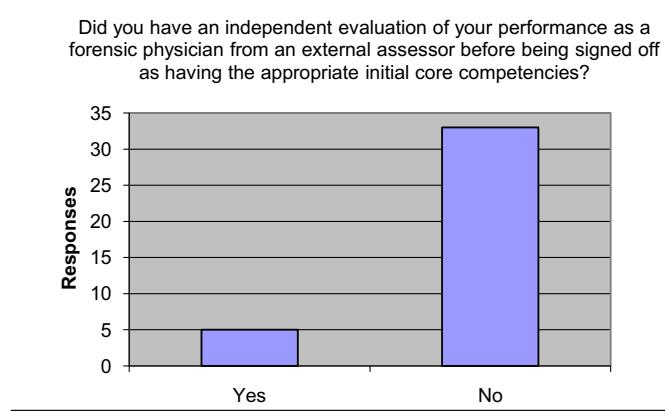
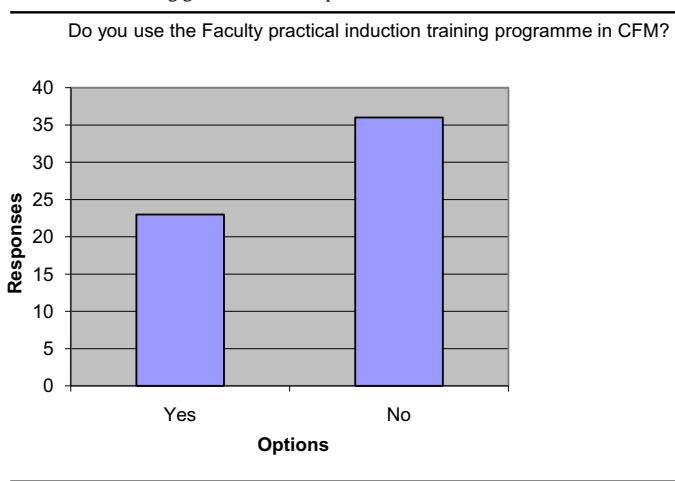


Table 12

Use of FFLM training guide—trainer response.



3.6. Support for trainers

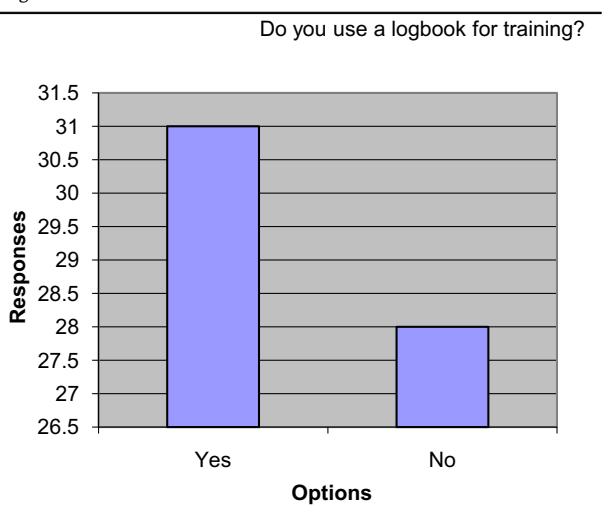
75% ($n = 44$) of the trainers responded that they had access to support from other trainers but only 53% ($n = 26$) felt the Faculty gives enough support to trainers. When asked how Faculty support could be improved suggestions included: ensuring the implementation of the concept of forensic medical training; appointment of trainers who have been appropriately trained and certified; a structured training programme with a formal means of assessment; more training resources of various kinds; the FFLM needs to ensure that the trainer role is better recognised and provide more support/training/peer group to those who are working as supervisors/trainers.

Comments received from trainees as to how training might be improved included:

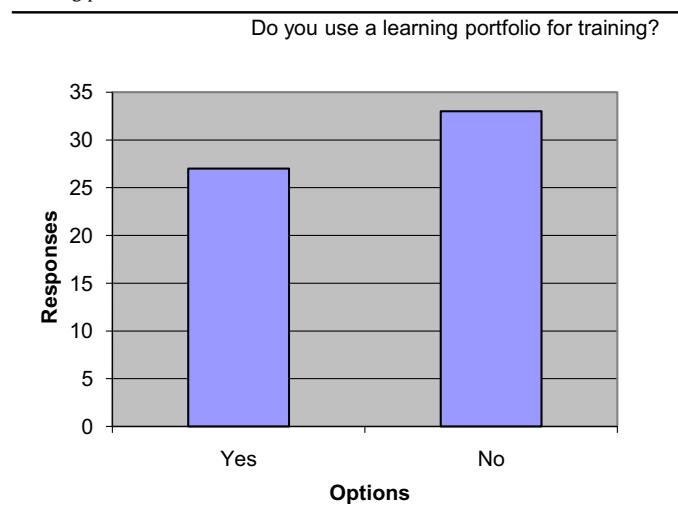
- a need to consider how trainees in rural areas access training;
- a need for formalised regular educational meetings/assessments/significant event audits/paid study leave/regular appraisal;

Table 13

Use of log book—trainer.

**Table 14**

Learning portfolio—trainer.



- more time shadowing experienced FME and more practical support would be beneficial; training needs to be more structured;
- there should be a formalised introduction prior to starting work, given the varied background of doctors working in forensic medicine;
- assessment of key competencies by a trained supervisor is required; although difficult to have hands on clinical supervision for all cases, as some are less common than others, discussion of cases with the supervisor should be promoted, provide feedback forms for the detainees for personal audit;
- sexual offence medicine induction, training and support excellent. The opposite true with custody work and prison medicine – minimal induction, no shadowing, lack of supervision/continuing professional development, no independent [doctor] to contact with concerns.

3.7. Interviews

The clinical directors (CD) had been in post over a period of 6 months–10 years; the medical directors (MD) 2.5–6 years. All were

Table 15

Use of summative assessment—trainer.

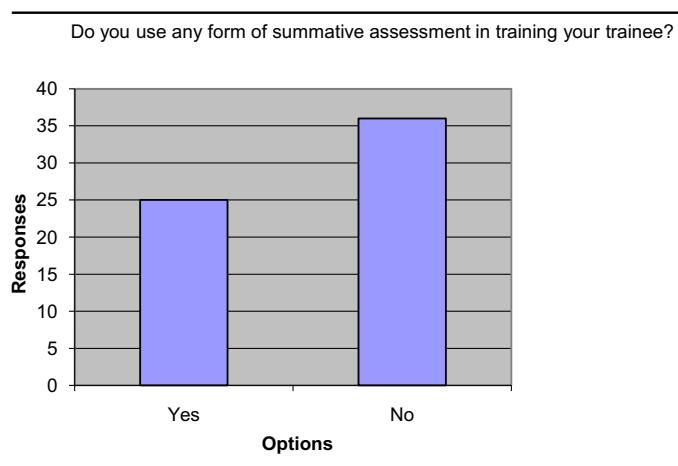


Table 16
Certificate of competence given—trainer.



personally responsible for overseeing training though had variable direct involvement. All thought that a post-graduate qualification (PGQ) in CFM was essential for a trainer in CFM, with previous experience of between 3 and 5 years, depending on the area and therefore exposure to caseload. One CD commented that:

"the time spent does not necessarily equate to experience because of the huge variation in caseload in different parts of the country – urban versus rural/suburban areas. To take the PG exam one needs to have at least 3 years' experience in the field, CFM is usually part of a portfolio of practice so building on other areas of work, therefore if working in a busy area will be good at training at the end of three years."

No overall background speciality was favoured by the directors because all felt that the trainer should have the relevant qualifications and experience in CFM and then would be able to train doctors coming from a variety of disciplines. This was highlighted by a comment from a MD:

"...hospital specialities, I did tend to feel, actually were nowadays more suited to some of the forensic element of the forensic medical

Table 17
Independent evaluation—trainer.

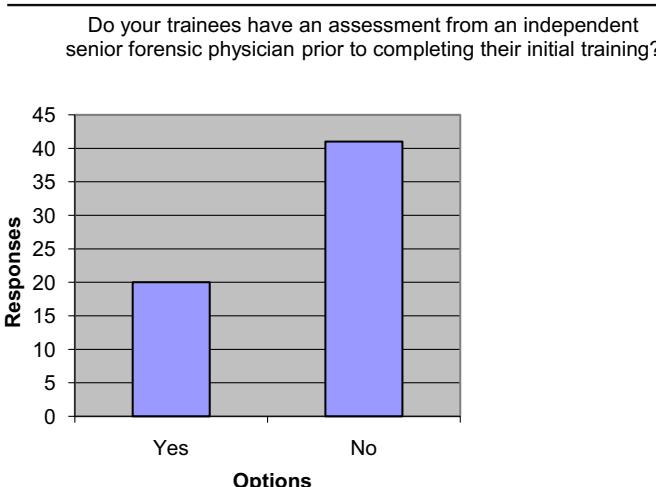
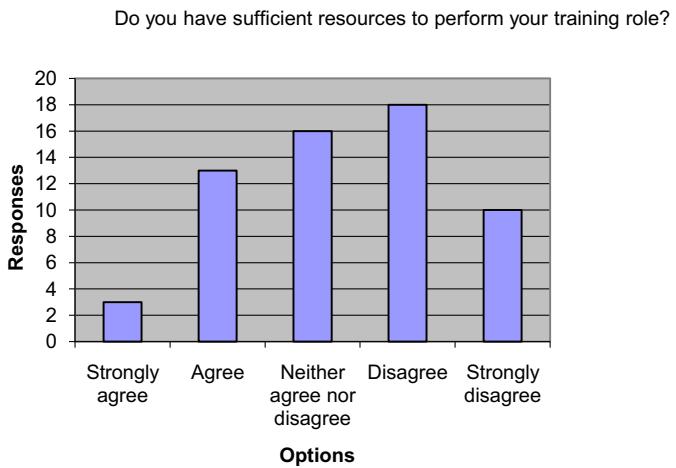


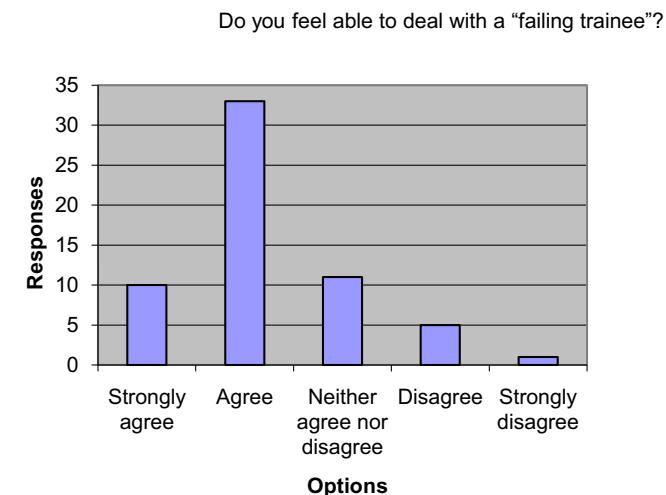
Table 18
Resources for training role.



work than GPs. GPs as a profession are taught to be imprecise.... as a GP trainer, I was taught to teach people to cope with uncertainty and to say it's ok, I don't know what this condition is, it's ok, I'm fairly sure it's not something dangerous.... In forensic medicine, I think the role is completely different in that one has to be very precise about certainly the forensic and the criminal justice element have to be very precise, and that fits better with the mentality of hospital doctors who are very precise about things. They're very black and white, and I've found that hospital specialities such as surgeons, I can remember an orthopaedic surgeon we had and a gynaecologist – they were very good at this work, they were very precise, their work was very thorough, and their statements were very thorough."

Most directors felt that specific training to be a supervisor was required, two MDs thought it was desirable, and three of the directors felt it was essential to have a teaching/training qualification, one suggesting a minimum of the certificate in educational supervision.

Table 19
Ability to deal with a "failing trainee".



One director was of the view that experience and not a qualification was perhaps more important but admitted he knew little of the current qualifications available including the new Membership exam.

Another director was particularly concerned at time scales for implementation of the requirement of a PGQ in the field and spoke of the need for a period of transition:

"I think in due course, one might wish to work towards this, but I'm very conscious that if one isn't careful, one could end up with no one able to train and no doctors trained."

There was a distinct difference in the quality of training provided in general forensic, as opposed to, sexual offence medicine (in the SARC). Two large and well established SARCS have very structured/formalised training, with excellent peer support, mentoring, shadowing, appraisal, and a process for formal signing off as competent, etc. Both of the clinical directors are trained trainers. One SARC director provided by email, after the interview, an excellent example of a process used to outline an individual doctors' requirement for training with a timetable of when this should have been achieved.

However both these SARCS were well established with secure funding and a high caseload. In less busy rural/suburban areas concerns were expressed with regard to resources in terms of leadership and protected training time. Overall training elsewhere was far less structured with two medical directors expressing some uncertainty about whether they are personally responsible for overseeing the training. This suggests that training is not a priority in these organisations as the line management would be clearer if it were.

In the outsourced companies there was inadequate funding for training and the lack of motivation amongst doctors seems to be a major problem. Those doctors working for outsourced companies seemed reluctant to attend training unless it was paid for. Several directors stated that they can't currently insist on continuous professional development training but they could if it was a formal requirement. Doctors working for one outsourced company refused to allow the medical director to look at their notes because of 'confidentiality' reasons, a stance that is unacceptable – to refuse to be involved in clinical governance.

The Faculty initiatives were generally considered favourably although many did not use the documents provided and one director thought that the guidance was sometimes rushed out and needed subsequent tweaking. Very little use was made of an independent assessment of competence. Appraisal arrangements were poor in most set ups. One director commented that: "Not allowed to do appraisals because they [the doctors] are not employees".

One MD stated that:

"one of my bugbears is that there's no qualification for FME work at the moment. The fact that you can just be a newly qualified doctor and then go off to do FME work, which, when you see the kind of work that FME doctors are doing, is frightening. So I think there needs to be a minimum standard of entrance qualification – whether that's initial GP training or A&E training – but I think it has to be certainly several years post-graduate speciality [training] – and I would agree that there has to be some sort of [standard] – whether it's a certificate or full membership or something – the Faculty approves that there's a minimum standard".

Many of the directors called for the early introduction of national standards commenting that although this would be difficult and costly it would be fair for all providers if there was a national standard for forensic physicians and national governance arrangements

"There are no set standards, no enforceable standards ...If there was a performer's list for FMEs ...if that were to come into force on

1st January 2011 then that would be a good thing – it would be a costly thing but at least you'd get the ball rolling."

Overall huge concerns were raised about the current disparity in quality of service provision:

"...it's like doing A&E work without any of the facilities, so its cutting edge stuff at the front line, with the most precarious of patients most of the time; in some ways it's fantastic that not more things go wrong than do actually go wrong."

Although the GMC³ puts the onus on individual doctors to maintain and further develop competence and performance, guidance as to the exact competencies and clinical standards should be set by the Faculty. Interestingly the interim quality standards⁶ were on the whole well received by the MD/CD. Most recognised that they were aspirational but thought they should be as the Faculty is an academic standard setting body. Most welcomed the setting of standards and thought they should be compulsory as a way to level the playing field.

4. Discussion

The aim of this research was to gather the views of recent trainees in the field of CFM, those responsible for training (medical and clinical directors), and those that actually do the training, as to how the relevant GMC standards are currently being met in initial on-the-job training in the CFM. The results outlined above provide a snapshot of the current situation in parts of the UK.

There has been little previous research on training in clinical forensic medicine. Elsewhere, a survey of how paediatric specialist registrars viewed the relatively newly introduced (in the 1990s) process of educational supervision found more than a third of trainees rated the educational supervision they had received as being closer to 'a complete waste of time' than to 'excellent'.¹⁹ A national survey of medical directors of the National Health Service trusts, educational supervisors and specialist registrars concluded that, although supervision is considered important, there is inadequate coverage and frequency of supervision activities and there was a need for more explicit guidance for those involved.²⁰ Even internationally it is difficult to draw comparisons as, for example, doctors in mainland Europe who practice clinical forensic medicine are generally pathologists, unlike in the UK where such practitioners are clinicians.

4.1. Initial training and supervision

The GMC have mandatory requirements with regard to induction and supervision so although three quarters of the trainee respondents in this survey had attended a local induction and an initial training course not all had done so, and this is clearly unacceptable. About one third had attended an FFLM approved course.²¹ But this leaves the question of whether the in-house training courses are fit for purpose – what is the current course content (syllabus)? Were the teaching methods appropriate? How is quality assured with subject matter experts presenting material? There is a need for FFLM to approve course content and teaching methods as well as providing on-going assessment in order to assure continued quality control.

One medical director whose company provides services in several constabularies suggested a way forward:

"what we're working towards is a set of standard template, approved and accredited training materials to be used in post-graduate situations, a little bit like the advanced – and this is something that the Faculty could do – a little bit like the advanced

life support group, or BASICS where they actually have pre-set lecture materials, and if you want to have a Faculty accredited course, then obviously, you deliver this material – well, you a) become an approved trainer, you b) have to deliver this material in this setting; and if they want to have a proper certificate, then obviously they have to pay their course fee of £200, a considerable part of which goes towards the Faculty."

The period of shadowing for trainees was very variable with a significant minority not doing any shadowing which is clearly a concern. As mentioned by the directors in interview, the period of shadowing can be tailored to an individual doctor's requirement based on their previous experience and progress in training, including exposure to caseload, but some direct observation of practice should surely occur. Previous research⁹ has highlighted the need for a consistent approach to supervision which has been seen as a poor learning experience if the supervisors are not working to the same standards. Furthermore it is clear that many supervisors currently providing training are not subject matter experts and do not have any post-graduate qualifications in clinical forensic medicine. Supervisors must have relevant qualifications and experience and undertake appropriate training to perform responsibilities such as overseeing an induction programme, conducting in training appraisal.²²

It is very important when trainees start to work unsupervised that they still have access to a senior forensic physician for advice; reduced clinical exposure in certain areas of practice may mean that support for new trainees needs to be continued for longer – as mentioned by a SARC CD where case load is low. The decision to call for advice is based on clinical judgment, on previous feedback on decisions, and is an important safety mechanism.²³ For the learner to develop confidence the supervisor must be able to give good feedback.

This further provides support for the idea of delivering sexual offence medical services through a small number of regional SARCs, as centres need to be large enough with a high enough case load, for structured training to work properly.²⁴

GMC standards for trainers also have requirements as outlined above. Many of the doctors currently involved in training new FPs consider that the Membership of the FFLM, and a period of experience in the field of clinical forensic medicine, is essential to perform the role of the "trainer". There was also a perceived need for trainers to receive training, on-going supervision, and review of their performance as trainers. In the trainer survey although 49% stated that they had received training the examples given were diverse and not all appropriate. Supervision has three functions educative, supportive, and managerial or administrative.²⁵

Currently in the field of clinical forensic medicine, doctors have come from a wide variety of backgrounds. Of the respondents one third of the trainees had completed specialist training as supposed to two-thirds of trainers. There was a clear steer that general practice and emergency medicine were the best backgrounds but that with the right training other background disciplines were suitable. Given such a wide variation in the skills of the doctors currently entering the discipline, it is arguable that the skills of the supervisor need to be greater.

Most trainees certainly did not have appropriate supervision with just over half having a named clinical/educational supervisor and only just over a third feeling that they had good clinical supervision at all times. Regular meetings and protected time for supervisor/trainee meetings is poor. Previous research²⁶ has suggested that good supervision can reduce stress levels of doctors in training.

Over half kept a log book but then a third did not discuss this with their supervisor; and over half kept a learning portfolio but a quarter didn't discuss this with their supervisor. Use of the FFLM

documentation, the practical induction training guides with the certificate of competence and independent evaluation of performance, was infrequent. The Faculty's practical induction training programmes have been in existence since 2002 for general forensic medicine²⁷ and 1997 for sexual offence medicine.²⁸

The overwhelming concern was lack of resources, time and money inextricably linked. Two-thirds of doctors in training had no access to an independent senior doctor to feedback any concerns regarding training. The trainers too thought that having an external source of advice and support would be useful in dealing with a failing trainee. More support from the Faculty for trainers and trainees is definitely required.

Why is this important? Doctors are bound by a number of duties⁵ but making the care of their patient their first concern is paramount and in order to do this they must provide a good standard of care. The training of doctors in the knowledge, skills and attributes to carry out their roles and responsibilities competently is essential. The current lack of acceptable and enforceable national standards in relation to training in this area is unacceptable. However because of the different entry competencies of individual forensic physicians a "one-size" training package may not fit all.

4.2. Current overall training provision in 2010

4.2.1. Initial training

In considering how the Faculty is to address the disparate quality of training and set standards for the future it is useful to review what is known about current training available.

The introductory course in CFM run by the FFLM and NPIA since 2005 provides a theoretical framework in the field of clinical forensic medicine and is suitable for newly appointed or prospective forensic physicians and custody nurses. The course content was initially developed by the Education and Research committee of the AFP in 2003 using a 'wisemen approach'.²⁹ The course is accredited by the University of Teesside as a University Certificate of post-graduate Professional Development (UCPPD) and uses a variety of teaching methods: small group teaching; multi-choice questioning; role play; assessment of medical notes and statement writing, and presenting evidence in court.³⁰ The small group learning allows students to question and challenge assumptions developing a better understanding of the topic under discussion.³¹ The course is residential over 5 days and in order to be awarded the University Certificate, which is not obligatory, two reflective case studies need to be submitted within three months of completion of the course. The students receive a comprehensive course handbook with Faculty documentation including the latest factsheets, guidelines, recommendations and pro formas.

There does need to be some assessment of communication skills in particular. Currently the FFLM/NPIA course assesses formal communication skills in the courtroom scenario and this has provided good evidence of the suitability of an individual doctor for this role.

With regard to sexual offence medicine there are two recognised centres of excellence. St Mary's Sexual Assault Referral Centre, established in 1986 (www.stmaryscentre.org), in conjunction with the University of Manchester, run a Forensic and Medical Examination for Rape and Sexual Assault Course (FMERSA) for doctors and nurses which involves two modules over twelve days. Assessment involves assessed essays and a record of a complement of visits to relevant agencies and observation of forensic examinations.

The Havens in London opened in 2000 (www.thehavens.org.uk) and run a number of courses covering adult and paediatric sexual assault examination and aftercare and courtroom skills.

However the emphasis on the above courses is theoretical especially in relation to clinical issues. Attendance on these

excellent courses needs to be followed up by a local induction programme and a period of shadowing and supervision by a properly qualified supervisor. This would be in line with NHS training, as the Gold Guide³² requires that each trainee should have a named clinical supervisor, usually a senior doctor, who is responsible for ensuring that appropriate clinical supervision of the trainee's day-to-day clinical performance occurs at all times, with regular feedback. This is further emphasised in Educating Tomorrow's Doctors³³ which recommends that trainees should gradually progress from working under close supervision to being fully autonomous.

The Association of Police Surgeons recognised this need for a period of shadowing in the late 1990s producing documents to guide practical on-the-job training (PIP)^{34,35} and the selection of "trainers".³⁶

The content of the PIP builds on the topics covered in the theoretical course, with the new learning related to previous learning and skills, so the competence of the student increases – an example of a spiral curriculum.³⁷ The programme also aims to use the learner's previous experience in other disciplines involving the trainee diagnosing their own needs and so formulating learning objectives, principles of andragogy.³⁸

The relationship between a Principal Forensic Physician as supervisor and the Assistant as trainee is based on an apprenticeship model which has been defined as the development of professional expertise through legitimate peripheral participation in a community of practice.³⁹ This model relates well with the principles of adult learning⁴⁰ and the programme can be used for reflecting on cases using a log diary and discussing cases with the supervisor, informal case-based discussion.

Case-based discussion (CBD) is used in the GP curriculum⁴¹ as a structured interview designed to assess the GP trainee's clinical and professional judgement in cases selected for discussion by the trainer or trainee. This is a mandatory part of the workplace-based assessment for the nMRCGP. This example of WPBA would translate fairly easily and appropriately to CFM, where not only can cases the trainee has been involved in be used for discussion but through discussion of the more unusual cases strategies can be developed to deal with such cases if they arise. At the end of the training period the trainee, after formative and summative assessment throughout, which in the final stages includes an interview with an independent doctor (separate from the current supervisor and an experienced forensic physician) to assess notes and statements, is issued with "The certificate of achievement of a standard of minimal acceptable competence in clinical forensic medicine." Having a second assessor improves reliability.

In this research, although a number of trainees kept log books and learning portfolios, full use of these documents was not made as a minority did not discuss the content with their supervisor.

Over the years there has been no mandatory requirement for a process of proof of competence to progress although there was at least one example of how such a system could be incorporated into the contractual role of a Principal Forensic Physician even though the implementation of the responsibility for training of newly appointed forensic physicians has recently been found to be of variable quality.⁹

4.2.2. Strengths and limitations

This study is an example of insider research which brings advantages and disadvantages. Often researchers are seen as outsiders who objectively carry out research whereas insiders, although practitioners with greater knowledge, may have strongly held opinions which can bias the results.

Overall the response rate to the questionnaire was good and has provided more information as to how on-the-job training is

perceived in areas outside London. The respondents to the questionnaire are likely to have been more highly motivated individuals who are currently Fellows, Members and Affiliates of the FFLM interested in training and giving their time to answer the questionnaire. There are likely to be other trainers and trainees whose views were not represented in the sample, which was self-selecting from current forensic practitioners on the FFLM mailing list.

All the directors contacted agreed to be interviewed and although it was clear that standards of practice varied all stated that they were committed to raising the quality of service provision even though time and resources remained huge problems. These interviews were not anonymous although confidentiality was assured. Prior and on-going relationships between the interviewer (MS) and directors must have had the potential to influence the answers that were received.

4.2.3. Conclusions and recommendations

The results of this research confirm the conclusions of the earlier studies looking at the situation in London in relation to trainers with Principal FMEs⁹ and trainees (or Assistant FMEs)¹⁰ which called for a more formal structure to the training of newly appointed FPs and the appointment of clinical/educational supervisors who should be appropriately trained and supported.

It was Boorstin who said that "*The greatest obstacle to discovery is not ignorance; it is the illusion of knowledge*" and this remains a significant problem in quality improvement in the field of CFM.

Smock⁴² used a case study, where the emergency physician was able to identify a self-inflicted gunshot wound and so prevent an unnecessary police investigation, to illustrate the importance of the incorporation of clinical forensic medicine into the emergency medicine training programme in the USA way back in 1991.

Stern⁴³ has also highlighted that the medical examination is a vitally important part of the evidence gathering process. Both complainants of assaults and suspects need to be appropriately assessed to avoid a miscarriage of justice, or a case being dismissed secondary to inadequate management of a detainee or incompetent evidence gathering.

The Ministry of Justice⁴⁴ has accepted Lord Bradley's recommendation⁴⁵ to explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS. However, whether clinical forensic medical services are included within "healthcare services" has not been fully clarified. Unless there are mandatory training standards outlined the variable quality of the current service provision will remain.

In the field of CFM, where doctors starting this work are from diverse backgrounds, it is essential that clear guidance is given by the FFLM as to the knowledge, skills, and attributes required to be a competent forensic physician and recommended quality standards have now been published.⁴⁶ In the future it would be advantageous to have specific outcomes, as individuals are not training from scratch, so a training programme can be tailored to the individual building on their current expertise and resulting in the same outcome. The educational/clinical supervisor has a pivotal role in overseeing the programme of training for a particular doctor building on their previous experience.³⁷

In credentialing forensic physicians it is proposed that a set of standards would be used such as an agreed entry requirement, along with a knowledge based assessment (the MFFLM examination), and workplace-based assessments such as case-based discussions, direct observation of procedural skills (DOPS), review of witness statements and courtroom skills, all linked to the appraisal and revalidation proposals already outlined by the Faculty. At the end of the process – the outcome – the doctor is recognised 'credentialed' as a competent forensic physician.

Stark⁴⁷ has previously discussed how essential it is that doctors working in the field be properly trained and forensically aware. The training in clinical forensic medicine, whether in general forensic or sexual offence medicine, needs to be formalised and properly funded. Much good work goes on despite inadequate funding because of highly dedicated doctors, dedicated not only to service provision but in the training of the next generation of forensic physicians.

The FFLM could promote the concept of inter-professional education (IPE). More and more multidisciplinary teams of doctors, nurses and paramedics are working in the clinical forensic medical environment assessing both suspects and complainants. IPE may help to 'develop insights, shared knowledge and teamwork skills that promote effective collaboration to deliver high-quality care efficiently'.⁴⁸ Educational methods that could be used include reciprocal shadowing with discussion and reflection and case-based/problem-based incidents which can be used to trigger learning.

The Home Secretary⁴⁹ has stated "that guidance as to the level of professional and clinical qualifications required for doctors or nurses is issued by the Faculty of Forensic and Legal Medicine (FFLM), which is part of the Royal College of Physicians." It is essential that the FFLM set standards for all healthcare professionals working in this field.

4.2.4. Recommendations

General

- Explicit quality standards need to be set for the content of training, theoretical and practical, including assessment (summative and formative) so that trainees, supervisors, and other stakeholders know exactly what the minimum standards are;
- Development of an outcome-based curriculum should be considered.

Training

- Initial training courses in CFM should be FFLM approved in relation to content, teaching methods, and with on-going assessment for quality assurance;
- On-the-job training needs to be supervised by a FFLM accredited trainer/supervisor who will be a subject knowledge expert with explicit training in effective supervision;
- Training needs to occur in a FFLM approved training setting;
- The period and content of training should be tailored to meet the needs and requirements of the individual doctor with the overall outcome: a competent forensic physician;
- The work-based assessments need to be valid and reliable, and resources, both in time and money, should be found to ensure that the outcome of the training programme is a competent forensic physician.
- The FFLM needs to work with the current providers of post-graduate qualifications to develop appropriate training for healthcare professionals working the field but also in particular for doctors wishing to take the Membership examination (MFFLM).

Supervision

- The FFLM needs to develop a framework to guide the professional development and accreditation of supervisors in the fields of general forensic and sexual offence medicine;
- The FFLM needs to provide support for the supervisors to perform this pivotal role which may include helping with "failing trainees" and providing independent advice for supervisors or trainees, when required.

Conflict of interest

None.

Funding

A grant for this research was received from the WG Johnston Memorial Trust Fund of the Faculty of Forensic and Legal Medicine.

Ethical approval

None declared.

Acknowledgements

This paper is taken from the thesis submitted by one of the authors (MS) for a Masters in Medical Education awarded by University College London. The thesis was dedicated to Dr Michael Knight "An Enlightened Master" = One who acts compassionately towards others by mentoring them.

Thanks are due to all the staff from the RCP/UCL course and fellow students over the past three years but particularly thanks go to David Parry (Tutor) and Shital Amin (fellow student).

Thanks to Professor Ian Wall, President of the Faculty of Forensic and Legal Medicine for facilitating the Faculty support and Sarah Llewellyn for her administrative support.

References

1. Payne-James JJ. Clinical risk and detainees in police custody. *Clinical Risk* 2010;16:56–60.
2. GMC. *Generic standards for speciality including GP training*, www.gmc.org.uk; April 2010.
3. GMC. *Standards for curricula and assessment systems*, www.gmc.org.uk; April 2010.
4. GMC. *Standards for deaneries*, www.gmc.org.uk; April 2010.
5. GMC. *Good medical practice. Guidance for doctors*, www.gmc.org.uk; November, 2006.
6. FFLM. *Interim quality standards in forensic medicine. General forensic (GFM) and sexual offence medicine (SOM)*, www.fflm.ac.uk; February, 2010.
7. PMETB. *Credentialing steering group Report*, www.gmc.org.uk; 19 April 2010.
8. FFLM. *AGM Registrar's report*, www.fflm.ac.uk; May 2010.
9. Stark MM. Principal forensic physicians as educational supervisors. *Journal of Forensic and Legal Medicine* 2009;16: 392–296.
10. Stark MM, Norfolk GA. Training of assistant forensic medical examiners in London, UK. *Journal of Forensic and Legal Medicine* 2009;17:194–7.
11. Llewellyn S. FFLM administrator. Personal Communication; February 2010.
12. Roff S, McAleer S, Skinner A. Development and validation of an instrument to measure the post graduate clinical learning and teaching educational environment for hospital-based junior doctors in the UK. *Medical Teacher* 2005;27(4):326–31.
13. DiCicco-Bloom B, Crabtree BF. The qualitative research interview. *Medical Education* 2006;40:314–21.
14. Mays N, Pope C. Assessing quality in qualitative research. *BMJ* 2000;320:50–2.
15. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006;3:77–101.
16. Silverman D. *Interpreting qualitative data*. London: Sage; 1993.
17. Denzin N. *The research act in sociology*. London: Butterworth; 1970.
18. NRES National Research Ethics Service. *Defining research*, <http://www.nres.npsa.nhs.uk/applications/guidance/#researchaudit>; 2009.
19. Lloyd BW, Becker D. Paediatric specialist registrars' views of educational supervision and how it can be improved: a questionnaire study. *Journal of the Royal Society of Medicine* 2007;100:375–8.
20. Cottrell D, Grant J, Jolly B, Kilmister S. Clinical Supervision of SpRs: where does it happen, when does it happen and is it effective? *Medical Education* 2003;37(2):140–9.
21. FFLM. *Guidelines continuing professional development*, www.fflm.ac.uk; 2010c.
22. Durguerian S, Riley W, Cowan GO. Training in assessment and appraisal: who needs it? *Medical Education* 2000;34:307–9.
23. Stewart J. Don't hesitate to call – the underlying assumptions. *The Clinical Teacher* 2007;4:6–9.
24. FFLM, Recommendations for Regional Sexual Assault Referral Centres. *Report of A Department of health working group*, www.fflm.ac.uk; August 2008.
25. Kilmister S, Cottrell D, Grant J, Jolly B. AMEE Guide No. 27: effective educational and clinical supervision. *Medical Teacher* 2007;29:2–19.
26. Newbury-Birch D, Kamali F. Psychological stress, anxiety, depression, job satisfaction, and personality characteristics in preregistration house officers. *Postgraduate Medical Journal* 2001;177:109–11.
27. FFLM. *A guide to practical induction training in clinical forensic medicine*, www.fflm.ac.uk; 2007.

28. FFLM. *A guide to practical induction training for sexual offences examiners*, www.fflm.ac.uk; 2007.
29. Harden RM. Ten questions to ask when planning a course or curriculum. ASME Medical Education Booklet No. 20. *Medical Education* 1986a;**20**: 356–65.
30. FFLM, NPIA. *University certificate in postgraduate professional development in forensic medicine*. University of Teesside, www.fflm.ac.uk; October 2008.
31. Crosby JR, Hesketh EA. Developing the teaching instinct. 11. Small group learning.
32. MMC A. *Reference guide for postgraduate speciality training in the UK*. 3rd ed. The Gold Guide; June 2009.
33. PMETB. Educating tomorrow's doctors – future models of medical training: medical workforce shape and trainee expectation; June, 2008.
34. Association of Police Surgeons. *A guide to practical induction training for sexual offences examiners*. Education and Research Committee, APS; 1997.
35. Association of Police Surgeons. *A guide to practical induction training in clinical forensic medicine*. Education and Research Committee, APS; 2002.
36. Association of Police Surgeons. Clinical forensic medicine. New trainer selection and re-approval; 2002.
37. Harden RM, Stamper N. What is a spiral curriculum? *Medical Teacher* 1999;**21**(2):141–3.
38. Knowles MS, Associates. *Andragogy in action: applying modern principles of adult learning*. San Francisco: Jossey-Bass; 1984.
39. Lave J, Wenger E. *Simulated learning: legitimate peripheral participation*. Cambridge: Cambridge University Press; 1991.
40. Kolb DA. *Experiential Learning: experience as the source of learning and development*. New Jersey: Prentice-Hall; 1984.
41. Riley B, Haynes J, Field S. *The Condensed curriculum guide for GP training and the New MRCGP*. The Royal College of General Practitioners; 2007.
42. Smock WS. Development of a clinical forensic medicine curriculum for emergency physicians in the USA. *Journal of Clinical Forensic Medicine* 1994;**1**:27–30.
43. Baroness Stern V. *The Stern Review. A report by Baroness Vivien Stern CBE of an independent review into how rape complaints are handled by public authorities in England and Wales*. Government Equalities Office, Home Office; 2010.
44. Ministry of Justice. Lord Bradley's report on people with mental health problems or learning disabilities in the Criminal Justice System: the Government's response; 30 April 2009.
45. Bradley, Lord. Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. DH; 2009.
46. FFLM. *Quality standards in forensic medicine. General forensic (GFM) and sexual offence medicine (SOM)*, www.fflm.ac.uk; October, 2010.
47. Stark MM. The medical care of detainees and the prevention of tragedy – the role of the forensic medical examiner. *Clinical Risk* 2000;**7**:15–9.
48. Freeth D. Interprofessional education. ASME; 2007.
49. Home Secretary, <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090318/text/90318w0006.htm>; 2009.